

Methods. Stakeholders (physicians and nurses) at an urban, safety-net pulmonary subspecialty clinic convened, reporting three primary challenges in ACP: discomfort discussing ACP in clinic, inability to locate AD documents and identifying patients appropriate for ACP. Consequently, a two-step intervention was implemented over 8 months: 1) education addressing ACP discomfort and 2) a novel reminder nudge with COPD-specific ACP criteria plus restructuring the clinic's AD process. As pulmonary providers were encouraged to complete patient ADs themselves or refer to an outpatient palliative care specialist, AD completion of patients with COPD seen in either clinic was tracked, using statistical process control p-charts.

Results. Before the intervention (June 2016-September 2017), the monthly AD completion rate among COPD patients seen in pulmonary and palliative subspecialty clinics was unstable by statistical process control, with a mean of 25.4% (range 13%-39%). The average monthly number of patients with COPD seen in both clinics was 106. With the education cycle (end October 2017), followed by the reminder nudge and AD paperwork optimization (March 2018), the new average AD completion rate was 28.8% (range 6-42%). Special cause signals indicating significant process change were a shift (December 2017-June 2018) and a point outside the 3-sigma upper control limit (June 2018).

Conclusions and Implications. Although the project aim was not met, the combined intervention was associated with special cause improvement in AD completion. The process was not under statistical control prior to intervention, and continued measurement is necessary to ensure sustained results. However, this study implies that with combined education, a nudge and re-organization, AD completion in this population can improve, thus improving outcomes for patients and families.

Compassionate Technology: Palliative Care Telemedicine in the Rural Hospital Setting (Q1741)

Matt Stinson, PA, Calaway Young Cancer Center, Glenwood Springs, CO. Elizabeth Belanger-Shugart, APRN, Valley View Hospital, Glenwood Springs, CO. Katherine Morrison, MD FAAHPM, University of Colorado, Aurora, CO. Maurice Scott, MD, The University of Colorado School of Medicine, Denver, CO.

Objectives

1. Recognize the challenges of providing palliative care in rural hospitals.
2. Describe the use of telemedicine to improve access to palliative care in our organization.

3. Reflect on how a similar approach may be used in other rural medical organizations.

Background. Early hospital-based palliative care is associated with significant improvement in patient quality of life and lower hospital costs. Although there is a robust presence of palliative care services in urban centers, there is a substantial disparity of care for seriously ill patients in rural areas. The medical literature demonstrates that telemedicine has been successful in the hospital setting for treatment of disease and in the home setting for palliative care. There is currently no available literature describing the use of telemedicine to address inpatient palliative care at rural hospitals.

Aim Statement. The purpose of the program is to determine the feasibility of utilizing telemedicine with palliative care services for adult inpatients at a rural community hospital.

Methods. An interdisciplinary team was formed at Valley View Hospital consisting of local providers, social workers, chaplains, and physicians from the University of Colorado Anschutz Medical Campus via teleconferencing. Palliative care consultations were performed with adult inpatients with a focus on advance care planning, symptom management, communication and prognostication. At subsequent visits, the patients were asked about the perceived value of the service and acceptability of the teleconferencing component.

Results. The program launched in January 2018, and 19 patients were seen in the initial 4 months of the service. 95% of patients tolerated teleconferencing well and reported satisfaction with the service. There was a 26% increase in completion and documentation of advance care plans following the visit. 30 patients were identified as needing palliative care services but could not be seen due to limited staff and time.

Conclusions and Implications. Telemedicine may be an option for rural healthcare facilities needing inpatient specialized palliative care services. Key components to program success include concurrent education for involved providers, adequate staffing, and sufficient technological support for telemedicine equipment and software.

Characterizing Life-Sustaining Treatment Decisions of Seriously Ill Veterans During Pilot Testing of the Veterans Health Administration's Life-Sustaining Treatment Decisions Initiative (Q1742)

Anne Walling, MD, University of California, Los Angeles, Los Angeles, CA. Karleen Giannitrapani, PhD, VA Health Services Research and Development Service/Stanford, Palo Alto, CA. Mary Beth Foglia, PhD MA RN, Veterans Health Administration, Washington D.C. Jill Lowery, PsyD, Veterans Health

Administration, Washington D.C. Lisa Lehmann, MD, Veterans Administration, Bedford, MA. Natalie Lo, OT, MPH, Center for Innovation to Implementation, Menlo Park, CA. Ariadna Garcia, MS, Stanford University, Palo Alto, CA. David Bekelman, MD MPH, University of Colorado, Denver, CO. Karl Lorenz, MD MS MSHS, Stanford/VA Palo Alto Health Care System, Palo Alto, CA.

Objectives

1. Describe essential elements of the Life-Sustaining Treatment Decisions Initiative.
2. Apply lessons learned from this evaluation of the Life-Sustaining Treatment Decisions Initiative to other implementation efforts related to improving advance care planning.

Background. To ensure that seriously ill Veterans' values, goals and preferences for life-sustaining treatments are elicited, documented and honored, VA's National Center for Ethics in Health Care implemented the Life-Sustaining Treatment Decisions Initiative (LSTDI).

Aim Statement. We aimed to characterize goals of care conversations (GOCC) and LST decisions at four VA pilot sites between 8/11/2014 and 11/14/2016.

Methods. Data from the patient medical record was linked to health factor (HF) data from the LSTDI template for initial GOCC. Descriptive statistics were performed for the following HF: Decision Making Capacity (DMC), Consent, Goals of Care (GOC) and Resuscitation status. We evaluated HF associations with DMC and chi-square t-tests were used to evaluate comparisons. We performed brief chart abstractions for rare instances of validity concerns.

Results. 6664 Veterans had ≥ 1 GOCC and were on average 72 years old, 93% male, 87% white, 61% urban. 35% of Veterans died. 15% with documented GOCC lacked DMC and $<1\%$ lacked a decision-maker. GOC varied for the cohort and included (more than one goal allowed): to be cured (8%), to prolong life (34%), to improve/maintain quality of life (62%), to be comfortable (53%), to obtain support for family/caregiver (8%), to achieve life goals (2%), and other (11%). Most with an initial LSTDI note had a DNR order (59%). Veterans lacking DMC were more likely to have comfort oriented goals (49% vs. 77%, $p<0.01$) and a DNR order (53% vs. 84%, $p<0.01$) compared to those with DMC. Most cases examined via chart abstraction due to data validity concerns were implicitly validated and identified opportunities to make adjustments to the LSTDI template to improve workflow.

Conclusions and Implications. LSTDI and goals of care documentation was successfully implemented at four pilot sites. Lessons learned will inform ongoing implementation across the VA nationally.

Integrating Creative Art Therapy with Palliative Care (QI743)



Jeanie Youngwerth, MD FAAHPM, University of Colorado School of Medicine, Denver, CO. Jean Kutner, MD MSPH FAAHPM, University of Colorado School of Medicine, Aurora, CO. Liz Somes, MD, Colorado University Denver Hospice and Palliative Med Fellowship, Denver, CO. Amy Jones, MA LPC, University of Colorado Hospital, Aurora, CO. Angela Wibben, MM MT-BC, University of Colorado Hospital, Aurora, CO.

Objectives

1. Discuss the integration of a creative art therapy program with a palliative care service.
2. Describe program evaluation outcomes with symptoms, and patient and family member perceptions regarding their experiences with creative art therapy.
3. Demonstrate the emotionally therapeutic effects of creative art therapy with patient examples.

Background. The University of Colorado Hospital (UCH) implemented a Creative Art Therapy (CAT) program in September 2016, offering CAT to hospitalized patients as a component of comprehensive Palliative Care services.

Aim Statement. To evaluate short term effects of the CAT session on patient symptoms and patient/family perceptions regarding their experience with CAT.

Methods. CAT was made available to all adult (18 and older) UCH Palliative Care Consult Service (PCCS) patients beginning in September 2016. The program evaluation occurred between 10/1/16-6/1/17. Patients self-selected a CAT session with a music or art therapist. The program evaluation consisted of a quantitative and qualitative component:

- a. Self-report of 3 symptoms that we hypothesized CAT would have a short-term effect on: pain, anxiety, and well-being (0-10 scale) using the Edmonton Symptom Assessment Scale (ESAS) prior to and following the CAT session; $n=12$ patients.
- b. Semi-qualitative patient and family member interviews using 6 questions to acquire in-depth information about perceptions of and experiences with the CAT session, administered within 1 day of the CAT session; $n=40$ patients and family members.

Results. During the study period, there were 366 CAT patient encounters. 12 patients completed pre/post-CAT session ESAS. Symptom scores showed a trend in improvement on a 0-10 scale for pain (4.8 to 4.3; $p=0.410$), anxiety (2.7 to 2.4; $p=0.699$), and well-being (5.8 to 4.8; $p=0.376$) from pre-intervention to post-intervention. 40 patients and family members completed semi-qualitative interviews. Qualitative analysis revealed the over-arching theme of improved